

Date	Last Name	First Name	AHCCCS ID #	DOB	Age
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Primary Care Provider	PCP ph. #	Health Plan	Accompanied By (Name)	Relationship
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Admitted to NICU: (Birth)	Current Medications/Vitamins/Herbal Supplements:	Risk Indicators of Hearing Loss:	Temp:	Pulse:	Resp:
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No			

Allergies:	Weight:			Length:		Head Circumference:		BMI:	
	lb	oz	%	cm	%	cm	%	kg/m ²	%

FAMILY/SOCIAL HISTORY: (Current Concerns/ Follow-Up on Previously Identified Concerns)

PARENTAL CONCERNS: How are you feeling about baby? Do you feel safe in your home?

DEVELOPMENTAL SCREENING TOOL COMPLETED: ASQ MCHAT PEDS

VERBAL LEAD RISK ASSESSMENT: (Blood Lead Test Required) Child At Risk Yes No Lives in High Risk Zip Code Yes No

ORAL HEALTH: White Spots on Teeth: Yes No Daily Brushing (Twice Daily by Parent) Fluoride Supplement
 First Dental Appointment Completed Scheduled Dental Home: Provider Name _____

NUTRITIONAL SCREENING: Feeds Self Nutritionally Balanced Diet Junk Food Soda/Juice
 Activity Supplements _____ Overweight Underweight Observation Referral

DEVELOPMENTAL SURVEILLANCE: Kicks a Ball Stacks 5-6 Blocks 50 Word Vocabulary Walks Upstairs/Runs Well
 Put Two Words Together Jumps Up Follows Two Step Commands Other _____

ANTICIPATORY GUIDANCE PROVIDED: Emergency/911 Gun Safety Drowning Prevention Choking Prevention
 Car /Car Seat Safety (Forward Facing) Safety at Home/Child-Proofing Sun Safety Trike/Bike Safety (Helmet Use)
 Establish Daily Routine Discipline/Redirection/Praise Provide Opportunities for Success/Choice Praise for Effort/Success
 Encourage/Support Wide Range of Emotions Read to Child Other _____

SOCIAL-EMOTIONAL HEALTH (OBSERVED BY CLINICIAN/PARENT REPORT): Family Adjustment/Parent Responds Positively to Child
 Appropriate Bonding/Responsive to Needs Self-Calming Frustration/Hitting/Biting/Impulse Control Communication/Language
 Sense of Humor Demonstrates Increasing Independence Plays Alongside Peers Other _____

COMPREHENSIVE PHYSICAL EXAM:

	WNL	Abnormal (see notes below)	WNL	Abnormal (see notes below)
Skin/Hair/Nails			Lungs	
Eyes/Vision/Red Reflex			Abdomen	
Ear			Genitourinary	
Mouth/Throat/Teeth			Extremities	
Nose/Head/Neck			Spine	
Heart			Neurological	

ASSESSMENT/PLAN/FOLLOW-UP:

LABS ORDERED: Blood Lead Testing (Required) TB Skin Test (If at Risk) Other _____

IMMUNIZATIONS ORDERED: HepA HepB MMR Varicella DTaP Hib IPV PCV Influenza
 Had Chicken Pox Other _____
 Given at Today's Visit Parent Refused Delayed Deferred Reason: _____
 Shot Record Updated Entered in ASIIS Importance of Immunizations Discussed Parent Refusal Form Completed

REFERRALS: ALTCS Audiology AzEIP CRS DDD Dental Early Head Start OT PT Speech WIC
 Specialist: Developmental Behavioral Other _____